# GAP Taskforce on Hospital Funding

Inaugural Meeting
Thursday, 9 June 2016, 10:30am to 12:00pm
Jubilee Room, NSW Parliament House, 6 Macquarie St, Sydney

---

## PREAMBLE

The inaugural meeting of the GAP Taskforce on Hospital Funding was held on Thursday, 9 June 2016, from 10:30am to 12:00pm, in the Jubilee Room at NSW Parliament House, 6 Macquarie St, Sydney NSW.

The Taskforce brings together senior executives from Commonwealth and State health departments and associated agencies, hospitals, private health insurers, private healthcare providers and specialist medical practitioners. It will work over the next six months to consider the structural redesign of the Australian Government Rebate on Private Health Insurance under the Federation reform, focusing on the proposed Commonwealth Hospital Benefit as a new funding model. The Taskforce is an initiative of public policy and implementation institute Global Access Partners (GAP).

The GAP Taskforce on Hospital Funding operates under the Chatham House rule of non-attribution and in accordance with the principles of the 'Second Track' process[1]. It is chaired by Mr Peter Fritz AM, Group Managing Director of TCG and Chairman of GAP.

## DISCLAIMER

This document represents a range of views and interests of the individuals participating in the meeting. Statements made during discussions are the personal opinions of the speakers and do not necessarily reflect those of Global Access Partners and its sponsoring organisations. Given the different perspectives of meeting participants, it should not be assumed that every Taskforce member would agree with every recommendation put forward.



[1] The 'Second Track' process is a new method of government consultation through which previously ad-hoc mechanisms for stakeholder engagement in policy development become part of the normal method for 'fast-tracking' solutions to key issues. The process brings together experts from relevant sectors (including government, business, academia, non-government organisations and consumer groups) with a like-minded approach to resolving the issues positively and driving practical outcomes. Working collaboratively, these groups identify problems, initiate discussions, prepare white papers, develop solutions and oversee their implementation. The 'Second Track' process has its origins in international diplomacy (the term '*Track Two Diplomacy*' was coined by Joseph Montville in 1981; *Foreign Policy*, Montville & Davidson, US).

MINUTES

## Welcome & Introduction

Members were welcomed to the Taskforce. Additional colleagues from state authorities will be invited to the next meeting.

The federal election campaign leaves the Australian government in 'caretaker mode' which limits the contribution which public officials can make to this discussion. Officials may only comment on factual proposals already in the public arena.

## Project Background - The Commonwealth Hospital Benefit (CHB)

The Taskforce emerged from a series of conversations between Global Access Partners and the Department of Health about the 'wicked' problems facing Australian healthcare.

The debate on federation led by the Department of Prime Minister and Cabinet (PM&C) highlighted public sector activity, including taxation, education and health, which cuts across the traditional demarcations of Commonwealth and State government. A proposal for a Commonwealth Hospital Benefit (CHB) was outlined in a discussion document issued by the PM&C in 2015[2], although the government did not adopt the scheme.

The current Australian Government's approach to hospital funding is outlined in the COAG agreement signed by Commonwealth and State governments on 1 April 2016.[3] This document plans a three-year extension to the current hospital funding agreement, followed a review of long-term roles and responsibilities.

## Taskforce Objectives

For the group's proposed goals and anticipated outcomes, please refer to the Flyer and Terms of Reference attached.

## Members' Expectations

Members were invited to introduce themselves, outline their expectations of the consultation process and suggest objectives for the group.

[2] The CHB proposal was first formulated as Option 2 in the Reform of the Federation Discussion Document – Department of the Prime Minister and Cabinet (2015), Reform of the Federation Discussion Paper, pages 27-28; *https://federation.dpmc.gov.au/sites/default/files/publications/reform_of_the_federation_discussion_paper.pdf*

[3] Council of Australian Governments (2016), Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding - 1 April 2016; *http://www.coag.gov.au/node/537#1*

A representative from a large private health insurer said he was open-minded about the proposal, although he admitted that it would reduce their 'top line' by a quarter. The private insurance sector would support an extension of the National Efficient Price (NEP)[4] to the private sector to reduce the significant cost variations between private hospitals; however, it may prove difficult for such hospitals to bundle payments involving different health professionals.

Another member wanted to learn more about the proposition. Although it is not part of the current Government's health policy, the concept of funding neutrality between public and private hospitals is attractive, and could have practical benefits. The overlap in capability and capacity between public and private hospitals, and the extent to which private care can offer a genuine alternative to public provision, should be discussed.

Other members welcomed the opportunity to join the discussion about the CHB. Interest was expressed about its potential effect on private insurance premiums. Competitive neutrality is attractive in theory, but its ability to deliver competitive benefits remains to be seen.

BUPA is concerned that the proposal would encourage activity and 'churn', rather than improve, health outcomes. Private health insurers negotiate with private hospitals to control their costs, and if 40% of private hospital funding came from the government, the insurers would have less power to drive prices down.

The Independent Hospital Pricing Authority (IHPA) is interested in the views of other organisations and the role it could play in any new arrangements, while the Australian Healthcare and Hospitals Association (AHHA) is open to reform which heeds its core principles.

NSW Treasury seeks to understand the sector's complexities and the unintended consequences which major policy reforms can cause.

Catholic Health Australia would welcome a simpler system which removes perverse incentives, exposes hidden subsidies and improves contestability across public and private domains. The full scope of the CHB proposal should be examined, including its effects on ancillary cover and the Pharmaceutical Benefits Scheme (PBS). Payments to doctors are the 'elephant in the room', while the impact on social equity should also be considered. Private health insurance subsidies do not apply to people with incomes above means-tested limits, while the new proposal would fund everybody.

The Royal Australasian College of General Practitioners (RACGP) supports reforms which drive hospital efficiency, as it wants to shift funding from hospitals to general

[4] Independent Hospital Pricing Authority (2015), National Efficient Price Determination 2015-16; *https://www.ihpa.gov.au/publications/national-efficient-price-determination-2015-16*

practitioners (GPs) in primary and preventative care. St Vincent's Health will assess both the positive and adverse effects of any proposed change.

The Health Systems Policy group at the federal Department of Health is interested in the effects of hospital reform on regional organisations, such as primary health networks.

A consumer advocate said that any proposal which eliminates the inefficient private health insurance rebate would be a positive. However, the existing system of 'fee for service' rebates does not integrate care or meet consumer needs, and so extending fees for service to hospital funding might make the situation worse. Out-of-pocket expenses fund a substantial amount of healthcare, and making consumers pay more could affect the access of less affluent people to healthcare.

The Commonwealth Department of Health welcomes the opportunity to consider these complex questions as a participant, rather than organiser. It focuses on the core issues of hospital funding and private health insurance and ways to improve its value proposition to stakeholders. A health advisor hoped the Taskforce would resolve some complicated issues, while another member hoped the discussion would open a broader debate about the future of the health system.

The Australian Centre for Health Research (ACHR) urges greater hospital and health system efficiency through redesign and system change to benefit consumers, funders and providers of care.

GMHBA would welcome reforms which simplify the system, but warns the proposal still concentrates on activity, rather than outcomes. The impacts on Indigenous people and those in remote areas should also be modelled carefully.

Brisbane's Mater Health agrees that the 'devil is in the detail', and would like to see a clear value proposition for funders. Bundling doctor payments would be challenging, given the likelihood of opposition from clinician representative bodies, but offers a key to 'change the dynamic' and should not be shied from.

## Rules of Engagement: The "Second Track" Process

Attendees representing other members were invited to future meetings in their own right. The Taskforce will meet four times for 90 minutes over the next six to nine months. Proceedings are recorded under the Chatham House rule of non-attribution and will be distributed to members for review before the next meeting. After the members' desired outcomes are defined, subsequent meetings and sub-groups facilitated by Global Access Partners will work to deliver them. GAP's managing director Catherine Fritz-Kalish FK is available to answer questions at any time.

## Global Access Partners

GAP works 'under the radar' and has achieved a great deal over the last 16 years. It is easy for people to describe what is broken and why it should change, but all too often they call for government remedies, rather than taking action themselves. GAP encourages Taskforce members to carry out their own recommendations. This group has unique access to the levers of power and has 'no excuses' to fail. The Taskforce should not merely restate the problem and offer half a dozen options, nor should it prejudge the choice of a single solution, but it must itself lead the implementation of change.

The CHB proposal can be discussed as a 'strawman', as the complexities of the healthcare sector cannot be encapsulated by a single concept. Members have unwittingly prepared for the task over their whole careers and need only bring their experience to the table. Issues should not be seen in isolation, as Australia suffers when agencies operate in silos and fail to cooperate to solve mutual problems.

## Retaining the Status Quo

One member questioned the supposition that change was required, and suggested the status quo might prove a better option. Considering a significant change in isolation from other important initiatives, such as Medical Homes, could prove a mistake and should not be relied on to improve outcomes without reference to other elements in the system. The reform could drive greater use of services, increasing costs rather than reducing them, and members should include retention of the status quo as a viable alternative.

## Commonwealth Hospital Benefit: Overview of key elements & policy drivers

- ***Current Funding Streams***

The Commonwealth currently funds public and private hospital care through a number of channels. Annual subsidy to the States and Territories for public hospital care is estimated to grow from $17 billion to over $20 billion in the near future. An additional $3 billion is allocated through the Medicare Benefits Schedule (MBS) for in-hospital medical services, while the Private Health Insurance Rebate costs another $6 billion a year, with forward estimates suggesting it will swell by another billion by 2018-19.

- ***The CHB Model***

The CHB scheme would amalgamate these three funding streams into a single pool, with the Commonwealth supporting the care of individuals in both public and private

hospitals by paying a percentage of the NEP[5] of particular procedures. The NEP is independently calculated, and has placed significant downward pressure on the cost of public hospital care since its launch three years ago.

It was noted that the published CHB proposal did not specify some necessary details, including the important matter of payment arrangements for doctors.

## Discussion

- ***Transparency***

Transparency is the key driver of change in the CHB model. Whatever state the patient is in and whatever costs the hospital incurs, the Commonwealth would pay the same percentage of the NEP (40%), encouraging the hospital to drive down costs. Rather than attempting to micromanage the business of individual hospitals, the CHB should force higher-cost hospitals to become more efficient. However, private hospitals do not employ the specialists whose services they use, unlike public hospitals which do employ their doctors.

- ***Hospital Costs***

The components of costs in private hospitals are similar to those in the public sector, with labour accounting for 50-60% of the total. Medical costs are bundled into a single payment for the entire treatment episode in the public health system, but are separated in the private system and paid for, in part, by private health insurers. Applying the NEP to the private hospital sector should have the same price-dampening effect experienced in public hospitals, because the underlying cost drivers are the same. The NEP is currently growing at just 2.1 % per annum, near the overall inflation rate, although total spending is also a function of volume as well.

- ***State Contributions***

Some state governments have 'topped-up' fees to hospitals which charge more for services than the Commonwealth-supported NEP. The NEP is calculated annually on a national basis and so is largely determined by costs in states, such as Victoria, which have



[5] IHPA sets the National Efficient Price (NEP) across the country, based on the projected average cost of a National Weighted Activity Unit after the deduction of specified Commonwealth funded programs and indexed depending on historic growth rates. The 2015-16 NEP is $4,971 per National Weighted Activity Unit 2015-16 (IHPA, 2015). National Weighted Activity Unit (MWAW) is the single measure of cost across all three service lines: admitted services, emergency department (ED) services and outpatient services (IHPA, 2013). Examples include:

- Limb amputation = 5.2978 NWAU
- Non-admitted Triage 1 ED presentation = 0.3123 NWAU
- General medical outpatient service = 0.0541 NWAU
- Palliative Care – terminal phase = 0.4297 NWAU/episode + 0.1265 NWAU/day

a larger proportion of patients and procedures. Despite additional state payments, the NEP is placing downward pressure on prices across the country.

- ***A Supply-Based Model***

The CHB would replace one supply-based model with another, and the absence of mechanisms to empower and express patient demand could reduce the incentive for suppliers to innovate. Hospital costs can be reduced in other ways, as preparing patients for routine operations, such as hip and knee replacements, for example, can reduce average hospital stays from five days to three. However, hospitals and private insurers have no incentive to instigate such schemes, as they pay the same fee regardless of the actual expenditure. Suppliers are thus geared to perform the same tasks in the same way in an inflated price system.

It was noted that the NEP had successfully controlled costs in public hospitals over the last three years, and as the efficient price is a function of best practice, hospitals which cannot meet that price have a powerful incentive to improve their efficiency and innovate.

- ***The National Hospital Cost Collection***

The NEP is calculated with reference to the National Hospital Cost Data Collection, a database which informs discussions between the States and Territories through the IPHA and other forums about variations in patient costs and ways to deliver healthcare more efficiently. Study of the underlying cost data highlights areas where similar procedures are more expensive than elsewhere, and the implementation of state benchmarking tools in New South Wales, Queensland and Western Australia and the development of a national benchmark is informing these important discussions.

The IPHA also runs a private national hospital cost data collection, based on a subset of private institutions, and although this is not publically reported, it has allowed private hospitals to engage in similar discussions about variations in cost. Part of the value of attaching a national price to procedures lies in creating a level-playing field for stakeholders to discuss ways to reduce variations in cost.

- ***Social Equity***

Although some Taskforce members expressed concerns about the CHB's implications for social equity, the NEP includes some provisions to address equality, including loadings related to Indigenous status[6] and children.

- ***Prosthesis Costs in Private Hospitals***

[6] There is a 4% adjustment for Indigenous patients, and more generous loadings for those in remote regions; the price adjustment for an Indigenous patient in a very remote area can amount to 28%. There is also a provision for specialist pediatric hospitals. – Data from a presentation by Dr Tony Sherbon, IPHA at the ACHR Workshop *"Building a Sustainable Australian Health System"* in Melbourne, Dec 2013

NEP payments to public hospitals are bundled to include all the costs of a treatment episode, including prosthetics, drugs and medical fees. Extending the system to the private sector would highlight the much higher costs of prosthesis there. Private sector implants are currently paid for through a separate schedule, in which over 10,000 items are ascribed fixed payments regardless of the actual price paid for them. Public hospitals are joining group-purchasing arrangements to reduce the prices they pay by buying in bulk, as they are not reimbursed for higher costs within their single bundled payment.

- ***Controlling Clinical Fees in Private Hospitals***

Prices inevitably rise when individual doctors are free to charge private hospitals what they want for their services although this pressure can be controlled by 'no gap' arrangements with private health insurers. Medical fees could be further moderated by private hospitals and hospital groups negotiating with individual doctors to deliver services for a fixed and agreed price, as is the case in the public hospitals, with those costs then reimbursed as part of a new bundled payment arrangement. Alternatively, arrangements could be made to allow insurers to carry out the negotiations themselves.

The solution was not specified in the original CHB discussion document, but that paper leans towards empowering private hospitals to negotiate fixed fees to standardise clinical costs and reduce upward pressure. The absence of market signals in some parts of country allows some doctors to charge well above the rates paid elsewhere and in excess of the arrangements private hospitals have with private health insurers for reimbursement.

- ***The Risk of Oligopoly***

All reforms risk unintended consequences, and the CHB might prove counterproductive if it encouraged the creation of oligopolies by forcing private hospitals to accumulate their purchases to reduce costs. Australia is a country of relatively small businesses providing localised medical services in a world where large global organisations operate on a much greater scale. The creation of purchasing blocks could effectively cut out smaller domestic service providers, although existing competition law should prevent hospitals from doing so.

One member with business experience argued that perfect markets were an economic myth and that the business prepared to lose the most money in a market would tend to dominate it. The government could choose to absorb the entire health market and become the sole provider of health services, but this is most unlikely to happen.

- ***Clinical Representation on the Taskforce***

The Taskforce currently lacks direct representation from hospital doctors, but this absence will be addressed at future meetings. The CHB model is 'one piece in a larger jigsaw', and given their importance to the success of any healthcare reform, hospital

doctors should have their say in the discussion. Invitations were sent to several clinical bodies which declined to attend, but the only criteria for participation is a willingness to consider change and the ability to act, and so relevant professionals can be added to the discussion as required.

- ***Clinician Attitudes to Reform of Private Sector Payments***

Doctors working in the private sector are paid directly by a patient's private insurance company, if they have one, and so private hospitals are effectively a platform for clinicians to operate their own businesses in. It would require a major shift for private hospitals to directly employ doctors, as public hospitals do, and pay them salaries. Change would require the cooperation of a substantial number of doctors which might be difficult to secure. Doctors have a variety of motivations and might accept a price in the public sector they would reject if offered by a private hospital. Leading specialists are not likely to accept terms dictated to them by private hospitals, and though additional payments could still be made outside the NEP, this would strip away some of its simplicity.

If private hospitals were offered the same bundled funding that public hospitals receive, then doctors would not have a choice about taking that price, unless they only took patients who paid them out of pocket. Many day-only private hospitals are owned by the doctors who work there, and so they would presumably be indifferent about whether they were paid fees directly as doctors, or received payments through their companies. Although persuading doctors to accept lower fees as part of bundled payments in private hospitals will be difficult, the approach should not be dropped, as it offers a powerful tool to reduce inflated prices. Removing the issue of clinician payments from the table would render further discussion pointless, as these fees are the crux of the issue. Technical efficiency can only be achieved if the clinician's vested interest in maintaining inflated fees is acknowledged and addressed. The market for specialists in Australia is changing, and they will not be able to set their own fees indefinitely.

- ***The Demand Side***

Price is a function of demand and supply, and while the CHB concentrates on the supply side, consumer demand much be considered, if unwarranted price variations and unnecessary hospital admissions are to be controlled. Greater cost transparency should not be underestimated as a tool to tackle disparities and could encourage insurers to press for lower prices by creating greater contestability. Such considerations should not inhibit consideration of the CHB, however. While the demand side is important and the situation is complex, change must start somewhere for progress to be made.
Insurance companies are already driving patients towards GP collectives which pay bulk bills. Current hospital funding allows some specialists to earn large amounts of money, and increasing transparency and competition can only serve to reduce their inflated fees. Many intelligent people have worked on this issue for a long time, but it is constitutionally difficult to control what private practitioners can charge. Setting up

competitive models through the insurance companies could help to control costs more effectively than direct government action.

- ***Technical Efficiency***

The CHB aims to improve technical efficiency across the hospital sector. Although technical efficiency is only one element in the 'wicked problem' of health funding, it is a significant factor, as hospitals have well demonstrated inefficiencies and consume the largest portion of Commonwealth, State and personal health funding. While more work can be done on the demand side to improve allocative efficiency, both demand and supply are important areas of endeavor and can be pursued in parallel.

While accepting the importance of other elements, the Taskforce should therefore maintain its remit to focus on improving technical efficiency through the CHB. There are many health service issues, including primary healthcare, demand management, industrial relations and 'big pharma' which could be discussed, but while members are free to raise whatever issues they think relevant, the group as a whole should retain its focus on the CHB.

The CHB proposal aims to reduce costs and improve technical efficiency. The need to improve efficiency was highlighted in a recent study published by the National Health Performance Authority[7] which highlighted the higher costs of routine procedures in hospitals in the ACT and WA compared to Victoria[8]. All these costs are funded by the tax payer, rather than patients through out-of-pocket expenses, and such significant price variations are a serious problem when public hospitals consume almost $50 billion of Commonwealth funding every year. When the same outcomes can be achieved by some hospitals at half the cost, there is a clear imperative to improve efficiency and drive down costs where possible.

Although less information is publically available about private hospital costs, it can be fairly assumed they will also have significant variations. Activity-based funding should serve to moderate growth in public sector costs, and the CHB would at least begin to address the problem of inflated costs in the private sector.

[7] NHPA (2015), Cost of acute admitted patients in public hospitals from 2011-12 to 2013-14; released in April 2016; *www.myhospitals.gov.au/our-reports/cost-of-acute-admitted-patients/april-2016/report*

[8] Ibid. - The National Health Performance Authority ranked hospitals around the country according to how much it cost to perform similar procedures and how long patients stayed in hospital, in a report released on 28 April 2016. Costs were assessed in 2013 and 2014 for common procedures such as appendectomy, child birth and heart failure, and the NHPA found that some public hospitals spend twice as much to provide a similar service to similar patients. Major metropolitan public hospitals in Victoria, such as Frankston Hospital, Casey Hospital, Western Hospital, Footscray and Dandenong Campus Hospital, had the lowest cost of care. However, Canberra Hospital spent $6,100 on a notional average service for acute admitted patients, compared to a national average of $4,220. Other high cost hospitals include Calvary Public Hospital and Sir Charles Gardener Hospital in the ACT and Fremantle Hospital in WA. ACT Health Minister Simon Corbell said the cost difference was caused by a range of factors, including higher average salaries for clinical staff and one-third of staff remaining on generous legacy Commonwealth superannuation schemes.

- ***Market Solutions Empowered by More Transparent Information***

Although wide variations in efficiency and costs persist in public hospitals, the private sector has even less impetus to improve technical efficiency and standardise prices at more reasonable levels. Market forces should have been sufficient to remedy major costs disparities, but one Taskforce member blamed high prices for private sector prosthetics, the 'laziness and ineptitude' of private health insurers, second-tier default benefits, and a lack of market power for their failure to do so.

Health funders and consumers lack the information they require to make informed and rational choices. The government should therefore publicise more price and efficiency information to allow consumers to choose the best performing services and to expose the high prices charged by some institutions for the same services available elsewhere at lower cost. Services which charge inflated prices would therefore be compelled to adopt best practice and reduce their prices for fear of losing business in the future. The government has a clear interest in reducing costs and improving efficiency, while patients do not want to spend any longer in hospital than necessary. Wholesale regulatory change would not be required if customers were empowered to make more informed decisions by greater transparency of data.

Other members argued that patient decisions are heavily influenced by clinical advice, and that patient choice about their healthcare is therefore an 'illusion'. Clinicians direct their patients to the services they believe are best for them, and so health is not a free market in which consumers can exercise control. Consumers trust clinicians to make decisions about their health and look to medical professionals and third-party experts for guidance, rather than government statistics. While there is scope to give consumers more information, one member questioned the extent to which consumers would make more economically rational choices as a result. Patients are concerned with their personal health outcome, not the cost of their treatment to the public purse, and the financial sector shows that people can make poor decisions despite a plethora of available data.

Most patients rely on their GP to inform their choices, but GPs also lack information about the medical outcomes, productive efficiency and overall value of the services they refer their patients too. GPs therefore need more detailed and reliable information, presented to them in a clear, objective and digestible manner, to inform their own advice to patients.

- ***The Role of Private Insurers***

Private insurers have a great deal of information about the cost and efficiency of different private hospitals, but are prevented from using it to inform their consumers and other funders about their relative performance. Removing some of these regulatory constraints could empower the transparency required to drive efficiency in the market.

Discussion of greater technical efficiency should acknowledge the central role of insurance and the impact a remodeling of insurance products could have, although this might in turn require a partial or complete overhaul of existing regulatory frameworks.

Many clinical bills are not eligible for rebates, and both patients and insurers only see 'half of the picture' if the total cost of private medical care is split between various funders. Doctors working in private sector obstetrics, for example, are now working shorter hours, but looking after more patients with shorter hospital stays and increasing their out-of-pocket bills to patients, thus forcing many back to the public sector.

- ***"Perfect is the Enemy of Good"***

Australia has an immensely complicated healthcare system, and no authority or stakeholder, be it the patient, GP, insurers or health authorities, has all the information required to make entirely rational decisions. The best that can be done is for people of good will to make progress in particular areas where they can. The impossibility of perfecting the entire system should not stymy action to improve particular aspects to some degree. Whatever their source or method of delivery, Australia has finite resources to spend on healthcare, and decisions must be made to maximise their utility. Bundling service payments for both the private and public sector would excite a great deal of opposition from those who profit from the status quo, but the problem must be confronted to be solved.

- ***Driving Efficiency***

While the primary benefit of the CHB proposal was initially said to be sector neutrality, its real motivation is the drive to improve cost efficiency by bundling payments per treatment episode. Extending the scope of the NEP and increasing price transparency in the private sector would expose doctors and hospitals which charge well above the average. This would force more expensive hospitals to reform their practices to reduce costs, not least because private insurers would tend to favour more economical hospitals. These insurers could still allow their clients to choose more expensive institutions, but they could insist such patients cover the extra expense out of their own pockets to address the moral hazard involved.

Although the cost of treatment will continue to be paid by a combination of public provision, private insurance and out-of-pocket patient expenses, expensive hospitals excluded from the insurers' preferred networks would therefore have a strong incentive to reduce their prices to the NEP. Private hospitals might not be in a position to insist that surgeons reduce their fees in the first instance, but greater transparency and payment bundling should at least dampen price pressures.

- ***The Potential for Substitution between Public and Private Hospitals***

While public hospitals do provide some services, such as emergency care, which private hospitals abstain from, private hospitals are capable of delivering the great majority of services provided by the public sector. Nearly all acute procedures are genuinely contestable between the public and private sphere, and private hospitals already carry out around 60% of elective surgery. Private hospitals could provide a complete range of services, but choose not to because they concentrate on the most profitable procedures. Their ability to undertake such business is limited only by a lack of physical capacity. While public hospitals ration demand by imposing or extending waiting lists, private hospitals will build additional capacity if required to meet increased demand.

Private hospitals will not provide procedures which insurers do not fund directly. HBV, for example, will not fund dialysis in private hospitals in Western Australia. Private hospitals can carry out almost any procedure which public hospitals provide, including organ transplants, but will not do so if this work is not funded by the private insurers which dominate their market share.

If a state treasury or health department found the private sector could offer dialysis to patients more cheaply than the public sector, for example, then it could move patients accordingly, but the authorities do not have the detailed price information required to make such decisions. The private sector has lower costs than public hospitals in some respects, but pays twice as much for some other components.

- ***International Experience***

Australia is far from the first country to face these issues, and international evidence suggests that certain solutions can work in a wide variety of different systems. While Australia's complex mix of provision and funding is unique, there is no reason to suppose that strategies which have managed diverse employment practices around the world would not be effective in this country. A sector-neutral approach to improve technical efficiency would further drive down prices in the public sector as well as private hospitals, as some private hospitals might be doing some things more efficiently. The private sector as a whole is not less efficient than the public sphere, except for its higher medical fees and certain other expenses.

## Vote of Thanks

Members were asked to forward further comments to GAP and thanked for their contributions, before the meeting was brought to a close.

**Next Meeting**

Thursday, 7 July 2016
10:30am – 12:00pm

Business Centre Boardroom
Hyatt Hotel Canberra
120 Commonwealth Avenue
Yarralumla ACT 2600

## ACTION POINTS

- Members willing to discuss the Taskforce's objectives and process can contact Catherine Fritz-Kalish at their convenience (0411 702 708, *cfritz@globalaccesspartners.org*)
- Members to send their comments on the meeting discussion to Olga Bodrova
- Olga Bodrova to circulate links to the Productivity Commission report on public and private hospitals, *http://www.pc.gov.au/inquiries/completed/hospitals/report;* and the report by the National Health Performance Authority on the comparative costs of services in public hospitals, *www.myhospitals.gov.au/our-reports/cost-of-acute-admitted-patients/april-2016/report*
- A presentation on the CBH to be arranged for the next meeting



 

# PARTICIPANT LIST

Ms Rebecca Bartel
Executive Director
Australian Centre for Health Research

Ms Olga Bodrova
COO & Director of Research
Global Access Partners

Mr Mark Booth
First Assistant Secretary
Health Systems Policy Division
Department of Health
Australian Government

Mr Michael Brennan
Deputy Secretary
Fiscal Group, The Treasury
Australian Government

Ms Abby Clark
Group General Manager Public Affairs
St Vincent's Health Australia
(representing **Mr Toby Hall**,
Group Chief Executive Officer)

Mr Mark Cormack
Deputy Secretary
Department of Health
Australian Government

Ms Rebecca Cross
Bupa Australia

Mr Mark Fitzgibbon
CEO & Managing Director
NIB

Ms Alanna Foster
First Assistant Secretary
Research, Data & Evaluation Division
Department of Health
Australian Government

Mr Peter Fritz AM
Chairman, Global Access Partners
Group Managing Director, TCG Group

Ms Catherine Fritz-Kalish
Co-founder & Managing Director
Global Access Partners

Ms Jenni Gratton-Vaughan
Benefits Manager
GMHBA (representing **Mr Mark Valena,** CEO)

Dr Shane Kelly
Chief Executive Officer
Mater Health Services Brisbane

Ms Emily Martin
Principal Adviser
Social Policy Division, Fiscal Group
The Treasury, Australian Government

Mr Charles Maskell-Knight
Principal Adviser
Department of Health
Australian Government

Mr Russell McGowan
Former Consumer Commissioner
Australian Commission on
Safety & Quality in Health Care

Ms Jennifer Nobbs
Executive Director, Activity Based Funding
Independent Hospital Pricing Authority
(IHPA) (representing **Mr James Downie**,
Acting CEO)

Ms Josephine Raw
Deputy CEO
The Royal Australian College of
General Practitioners (representing **Dr
Zena Burgess**, CEO)

Ms Cathy Ryan
Group Manager, Health Funds
St John of God Health Care
(representing **Dr Michael Stanford**, CEO)

Mr Joshua Shrubb
Executive Director Health & Justice
NSW Treasury (representing **Mr Robert Whitfield**, Secretary)

Dr Linc Thurecht
Senior Research Leader
Australian Healthcare & Hospitals Association (representing **Ms Alison Verhoeven,** CEO)

Mr Patrick Tobin
Director, Policy
Catholic Health Australia
(representing **Ms Suzanne Greenwood**, CEO)

Ms Vicki Wilkinson
Division Head
Social Policy Division, Fiscal Group
The Treasury, Australian Government

Mr David Withey
Director, Justice, Police & Emergency
NSW Treasury (representing **Mr Robert Whitfield**, Secretary